

ANONYMOUS (NO NAMES) SURVEY

Thank you for participating in this anonymous survey. This survey is a part of a study at University of California, Riverside on the nutritional (eating and drinking) habits of pregnant women. We would like to know what foods, drinks and medications you took during your pregnancy, during approximately what time period or trimester.

For each question please check ALL that apply. More than one box may be checked.

During your pregnancy, did you eat...			
	What kind?	How often?	When?
1. Meat? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> chicken <input type="checkbox"/> beef <input type="checkbox"/> pork <input type="checkbox"/> other: _____	<input type="checkbox"/> 1-3 times in entire pregnancy <input type="checkbox"/> 1-3 times per month <input type="checkbox"/> 1-3 times per week <input type="checkbox"/> 4-6 times per week <input type="checkbox"/> 7+ times per week	<input type="checkbox"/> beginning of pregnancy <input type="checkbox"/> middle of pregnancy <input type="checkbox"/> end of pregnancy
2. Fish? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> tuna <input type="checkbox"/> salmon <input type="checkbox"/> talapia <input type="checkbox"/> other: _____	<input type="checkbox"/> 1-3 times in entire pregnancy <input type="checkbox"/> 1-3 times per month <input type="checkbox"/> 1-3 times per week <input type="checkbox"/> 4-6 times per week <input type="checkbox"/> 7+ times per week	<input type="checkbox"/> beginning of pregnancy <input type="checkbox"/> middle of pregnancy <input type="checkbox"/> end of pregnancy
3. Canned Foods? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> fruit or vegetables <input type="checkbox"/> soup <input type="checkbox"/> tuna <input type="checkbox"/> other: _____	<input type="checkbox"/> 1-3 times in entire pregnancy <input type="checkbox"/> 1-3 times per month <input type="checkbox"/> 1-3 times per week <input type="checkbox"/> 4-6 times per week <input type="checkbox"/> 7+ times per week	<input type="checkbox"/> beginning of pregnancy <input type="checkbox"/> middle of pregnancy <input type="checkbox"/> end of pregnancy
4. Sugary Deserts? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> chocolate <input type="checkbox"/> ice cream <input type="checkbox"/> baked goods <input type="checkbox"/> other: _____	<input type="checkbox"/> 1-3 times in entire pregnancy <input type="checkbox"/> 1-3 times per month <input type="checkbox"/> 1-3 times per week <input type="checkbox"/> 4-6 times per week <input type="checkbox"/> 7+ times per week	<input type="checkbox"/> beginning of pregnancy <input type="checkbox"/> middle of pregnancy <input type="checkbox"/> end of pregnancy
5. Fast Foods? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> burgers <input type="checkbox"/> chicken products <input type="checkbox"/> french fries <input type="checkbox"/> other: _____	<input type="checkbox"/> 1-3 times in entire pregnancy <input type="checkbox"/> 1-3 times per month <input type="checkbox"/> 1-3 times per week <input type="checkbox"/> 4-6 times per week <input type="checkbox"/> 7+ times per week	<input type="checkbox"/> beginning of pregnancy <input type="checkbox"/> middle of pregnancy <input type="checkbox"/> end of pregnancy
6. Fresh Fruit? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> bananas <input type="checkbox"/> apples <input type="checkbox"/> oranges <input type="checkbox"/> other: _____	<input type="checkbox"/> 1-3 times in entire pregnancy <input type="checkbox"/> 1-3 times per month <input type="checkbox"/> 1-3 times per week <input type="checkbox"/> 4-6 times per week <input type="checkbox"/> 7+ times per week	<input type="checkbox"/> beginning of pregnancy <input type="checkbox"/> middle of pregnancy <input type="checkbox"/> end of pregnancy

During your pregnancy, did you drink...			
	What kind?	How many glasses/cans/bottles?	When?
1. Water? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> tap water <input type="checkbox"/> bottled water <input type="checkbox"/> home filtered <input type="checkbox"/> other: _____	<input type="checkbox"/> 1-3 total in entire pregnancy <input type="checkbox"/> 1-3 per month <input type="checkbox"/> 1-3 per week <input type="checkbox"/> 4-6 per week <input type="checkbox"/> 7+ per week	<input type="checkbox"/> beginning of pregnancy <input type="checkbox"/> middle of pregnancy <input type="checkbox"/> end of pregnancy
2. Energy Drinks? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Monster <input type="checkbox"/> Red Bull <input type="checkbox"/> Rockstar <input type="checkbox"/> other: _____	<input type="checkbox"/> 1-3 total in entire pregnancy <input type="checkbox"/> 1-3 per month <input type="checkbox"/> 1-3 per week <input type="checkbox"/> 4-6 per week <input type="checkbox"/> 7+ per week	<input type="checkbox"/> beginning of pregnancy <input type="checkbox"/> middle of pregnancy <input type="checkbox"/> end of pregnancy
3. Milk? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> whole <input type="checkbox"/> low-fat <input type="checkbox"/> skim <input type="checkbox"/> organic <input type="checkbox"/> other: _____	<input type="checkbox"/> 1-3 total in entire pregnancy <input type="checkbox"/> 1-3 per month <input type="checkbox"/> 1-3 per week <input type="checkbox"/> 4-6 per week <input type="checkbox"/> 7+ per week	<input type="checkbox"/> beginning of pregnancy <input type="checkbox"/> middle of pregnancy <input type="checkbox"/> end of pregnancy

4. Juice?	<input type="checkbox"/> orange <input type="checkbox"/> apple <input type="checkbox"/> juice blends <input type="checkbox"/> other: _____	<input type="checkbox"/> 1-3 total in entire pregnancy <input type="checkbox"/> 1-3 per month <input type="checkbox"/> 1-3 per week <input type="checkbox"/> 4-6 per week <input type="checkbox"/> 7+ per week	<input type="checkbox"/> beginning of pregnancy <input type="checkbox"/> middle of pregnancy <input type="checkbox"/> end of pregnancy
<input type="checkbox"/> Yes <input type="checkbox"/> No			
5. Beer or Wine?	<input type="checkbox"/> beer <input type="checkbox"/> wine <input type="checkbox"/> malt beverage <input type="checkbox"/> other: _____	<input type="checkbox"/> 1-3 total in entire pregnancy <input type="checkbox"/> 1-3 per month <input type="checkbox"/> 1-3 per week <input type="checkbox"/> 4-6 per week <input type="checkbox"/> 7+ per week	<input type="checkbox"/> beginning of pregnancy <input type="checkbox"/> middle of pregnancy <input type="checkbox"/> end of pregnancy
<input type="checkbox"/> Yes <input type="checkbox"/> No			
6. Coffee, tea, or soda?	<input type="checkbox"/> coffee <input type="checkbox"/> tea <input type="checkbox"/> soda <input type="checkbox"/> decaf beverages <input type="checkbox"/> other: _____	<input type="checkbox"/> 1-3 total in entire pregnancy <input type="checkbox"/> 1-3 per month <input type="checkbox"/> 1-3 per week <input type="checkbox"/> 4-6 per week <input type="checkbox"/> 7+ per week	<input type="checkbox"/> beginning of pregnancy <input type="checkbox"/> middle of pregnancy <input type="checkbox"/> end of pregnancy
<input type="checkbox"/> Yes <input type="checkbox"/> No			
7. Mixed drinks or liquor?	<input type="checkbox"/> mixed drinks <input type="checkbox"/> liquor/shots <input type="checkbox"/> other: _____	<input type="checkbox"/> 1-3 total in entire pregnancy <input type="checkbox"/> 1-3 per month <input type="checkbox"/> 1-3 per week <input type="checkbox"/> 4-6 per week <input type="checkbox"/> 7+ per week	<input type="checkbox"/> beginning of pregnancy <input type="checkbox"/> middle of pregnancy <input type="checkbox"/> end of pregnancy
<input type="checkbox"/> Yes <input type="checkbox"/> No			

During your pregnancy, did you take...			
	What kind?	How often?	When?
1. Over-the-counter medications?	<input type="checkbox"/> sinus decongestants <input type="checkbox"/> cough/cold syrup <input type="checkbox"/> ibuprofen (Advil) <input type="checkbox"/> aspirin <input type="checkbox"/> acetaminophen (Tylenol) <input type="checkbox"/> other: _____	<input type="checkbox"/> 1-3 times in entire pregnancy <input type="checkbox"/> 1-3 times per month <input type="checkbox"/> 1-3 times per week <input type="checkbox"/> 4-6 times per week <input type="checkbox"/> 7+ times per week	<input type="checkbox"/> beginning of pregnancy <input type="checkbox"/> middle of pregnancy <input type="checkbox"/> end of pregnancy
<input type="checkbox"/> Yes <input type="checkbox"/> No			
2. Prescription medications?	<input type="checkbox"/> prenatal vitamins <input type="checkbox"/> antidepressants <input type="checkbox"/> morning sickness meds <input type="checkbox"/> pain medication <input type="checkbox"/> other: _____	<input type="checkbox"/> 1-3 times in entire pregnancy <input type="checkbox"/> 1-3 times per month <input type="checkbox"/> 1-3 times per week <input type="checkbox"/> 4-6 times per week <input type="checkbox"/> 7+ times per week	<input type="checkbox"/> beginning of pregnancy <input type="checkbox"/> middle of pregnancy <input type="checkbox"/> end of pregnancy
<input type="checkbox"/> Yes <input type="checkbox"/> No			

General Information about yourself: Please check the best response.					
What is your age?					
<input type="checkbox"/> [18-20]	<input type="checkbox"/> [21-25]	<input type="checkbox"/> [26-29]	<input type="checkbox"/> [30-35]	<input type="checkbox"/> [36-39]	<input type="checkbox"/> [40+]
What is your ethnicity?					
<input type="checkbox"/> White	<input type="checkbox"/> Hispanic	<input type="checkbox"/> African-American	<input type="checkbox"/> Asian/Pacific Islander	<input type="checkbox"/> Middle Eastern	
What is your highest level of education?					
<input type="checkbox"/> Elementary School	<input type="checkbox"/> Middle School	<input type="checkbox"/> High School	<input type="checkbox"/> Some College	<input type="checkbox"/> College Degree	<input type="checkbox"/> Graduate Degree
What is your household income?					
<input type="checkbox"/> \$0-\$25,000	<input type="checkbox"/> \$25,001-\$50,000	<input type="checkbox"/> \$50,001-\$75,000	<input type="checkbox"/> \$75,001 - \$100,000	<input type="checkbox"/> \$100,000+	
How far along were you when you found out you were pregnant (what month)?					
<input type="checkbox"/> 1st	<input type="checkbox"/> 2nd	<input type="checkbox"/> 3rd	<input type="checkbox"/> 4th	<input type="checkbox"/> 5th	<input type="checkbox"/> 6th <input type="checkbox"/> 7th <input type="checkbox"/> 8th <input type="checkbox"/> 9 th
How many weeks pregnant are you now? Or how many weeks postpartum? _____.					